CLAIM CORRECTION REQUEST FORM

Provider Name:		AHCCCS Provider ID #:		Provider Representative:	

Please complete one request form for each Provider ID.

Recipient's name:	**Recipient's AHCCCS ID:**	**Dates of service:**	**Billed amount:**
CRN:	**Fields to be Changed / Comments / Questions:**		
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This is to certify the information submitted and changes listed/requested on this Claim Correction Request Form are true, accurate and complete. I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.		**Date**
Signature of Provider Representative (Required):		